MANDATORY PASSAGES AND LANGUAGE FOR MC+ MANAGED CARE HEALTH PLAN HANDBOOKS

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WELCOME TO MC+ MANAGED CARE

You live in an area of the state where you get most of your benefits from a MC+ Managed Care health plan. Each MC+ Managed Care health plan member must have a Primary Care Provider (PCP). A PCP manages a member's health care. In non-health plan areas of the state, individuals eligible for MC+ receive health care services through MC+ Fee-for-Service. There are a few services that members in a MC+ Managed Care health plan will receive from MC+ Fee-for-Service. MC+ Fee-for-Service members must go to an MC+ approved provider. Call 1-800-392-2161 for a list of MC+ approved providers.

KEEPING YOUR INSURANCE

It is very important you let your caseworker know when your address changes. Important letters and information will be mailed to the address you have given. You or your children could lose your MC+ coverage if you do not respond to State requests for information. Please make sure that you answer all mail from the State.

INTERPRETER SERVICES

If you do not speak English call PLAN PHONE NUMBER to ask for help. We can help if you do not speak or understand English.

- We will get you a translator when needed.
- We may have this book in your language.
- We will get a copy of the grievance and appeal rules in your language.

PRINT IN SPANISH AS WELL AS ENGLISH and in prevalent languages (Bosnian, Vietnamese, others)

VISUALLY AND HEARING IMPAIRED MEMBERS

We have this handbook in an easy to read form for people with poor eyesight. Please call us at PLAN PHONE NUMBER for help. We have a special phone number for people with poor hearing. Members who use a Telecommunications Device for the Deaf (TDD) can call PLAN PHONE NUMBER.

PRINT IN A LARGER FONT

PRINT THE ABOVE INFORMATION ON THE FIRST PAGE OF THE HANDBOOK.

MEDICAL DISABILITY/MC+ FEE-FOR-SERVICE

If you get Supplemental Security Income (SSI), meet the SSI medical disability definition, or get adoption subsidy benefits you may stay in MC+ Managed Care or you may choose to get MC+ Fee-for-Service using MC+ approved providers. Call the MC+ Managed Care Enrollment Helpline at 1-800-348-6627 for information and to make your choice.

CHANGING TO ANOTHER MC+ MANAGED CARE HEALTH PLAN

You may change MC+ Managed Care health plans for any reason during the first 90 days after you become a MC+ Managed Care health plan member. You will also be able to change during your annual open enrollment time. Call the MC+ Managed Care Enrollment Helpline at 1-800-348-6627 for help in changing MC+ Managed Care health plans.

You may be able to change MC+ Managed Care health plans after 90 days. Some reasons for changing include but are not limited to:

- you have moved out of the MC+ Managed Care area;
- your PCP is no longer with NAME OF PLAN and is in another MC+ Managed Care health plan; or
- your specialist or other health care provider you are currently getting services from is no longer with NAME OF PLAN and is in another MC+ Managed Care health plan.

NAME OF PLAN cannot make you leave our MC+ Managed Care health plan because of a health problem.

NEWBORN COVERAGE

If you have a baby you must:

- call your caseworker at your local Family Support Division as soon as possible to report the birth of your child. The State will give your baby an identification number, known as a health insurance number.
- call NAME OF PLAN at PLAN PHONE NUMBER; and
- pick a PCP for your baby in NAME OF PLAN network.

Your baby will be enrolled in NAME OF PLAN. Call the MC+ Managed Care Enrollment Helpline at 1-800-348-6627 if you want a different MC+ Managed Care health plan for your baby. This is the only phone number you can use to change your baby's MC+ Managed Care health plan. You cannot enroll the baby before birth. You cannot change MC+ Managed Care health plans for your baby until after your baby is born and has an identification number. The Family Support Division staff cannot change your baby's MC+ Managed Care health plan.

To be sure your baby gets all the services he or she needs, continue to use your current MC+ Managed Care health plan and PCP until the new MC+ Managed Care health plan is effective. If you want to change your baby's MC+ Managed Care health plan it will be, at most, 45 days before the new MC+ Managed Care health plan is effective.

CHANGES YOU NEED TO REPORT

If you move, it is important that you **report your new address** by calling your local Family Support Division Office and the MC+ Managed Care Enrollment Helpline at 1-800-348-6627. Then call NAME OF PLAN at PLAN PHONE NUMBER. Your MC+ Managed Care coverage may be affected. If we do not know where you live, you will miss important information about your coverage. Changes you need to report to your local Family Support Division office include:

- family size (including the birth of any babies);
- income;
- address;
- phone number; and
- availability of insurance.

INSURANCE

You have MC+ Managed Care health insurance through NAME OF PLAN. You may have other health insurance too. This may be from a job, an absent parent, union, or other source. If you have other health insurance besides MC+ Managed Care health insurance, that insurance company must pay for most of your health services before NAME OF PLAN pays. If your other health insurance covers a service not covered by MC+ Managed Care, you will owe your provider what your insurance does not pay. It is important that you show all your insurance ID cards to your health care provider.

NAME OF PLAN and your other health insurance policy have rules about getting health care. You must follow the rules for each policy. There are rules about going out-of-network. Some services need prior approval. You may have to pay for the service if you don't follow the rules. For help, call NAME OF PLAN at PLAN PHONE NUMBER.

If you have health insurance other than MC+ Managed Care or your insurance changes, details about your insurance are needed. Have your insurance card with you when you call the following numbers.

You must call:

- NAME OF PLAN at PLAN PHONE NUMBER; and
- the MC+ Managed Care Enrollment Helpline at 1-800-348-6627; or
- your local Family Support Division Office.

You must report insurance you get through your job or you could lose your MC+ Managed Care benefits. MC+ has a program that can pay the cost of other health insurance. The name of the program is Health Insurance Premium Payment (HIPP).

- Call your local Family Support Division Office if your job has health insurance.
- Call Third Party Liability (TPL) at 573-751-2005 to ask about the HIPP program.

You must call NAME OF PLAN at PLAN PHONE NUMBER or your local Family Support Division office if:

- you get hurt in a car wreck;
- you get hurt at work;
- you get hurt and have a lawyer; or
- you get money because of an accident.

YOUR RIGHTS AS A MC+ MANAGED CARE HEALTH PLAN MEMBER

You have the right to:

- be treated with respect and dignity;
- receive needed medical services;
- privacy and confidentiality (including minors) subject to state and federal laws;
- select your own PCP;
- refuse treatment;
- receive information about your health care and treatment options;
- participate in decision-making about your health care;
- have access to your medical records and to request changes, if necessary;
- have someone act on your behalf if you are unable to do so;
- get information on our Physician Incentive Plan, if any, by calling PLAN PHONE NUMBER.
- be free of restraint or seclusion from a provider who wants to:
  - make you do something you should not do;
  - punish you;
  - get back at you;
  - make things easier for him or her.
- be free to exercise these rights without retaliation;
- receive one copy of your medical records once a year at no cost to you.

YOUR HEALTH BENEFITS IN MC+ MANAGED CARE

Some benefits are limited based on your eligibility group or age. The benefits that may be limited have an "*" next to them. Some services need prior approval before getting them. Call NAME OF PLAN at PLAN PHONE NUMBER for information about your health benefits.

- Adult day health care
- Ambulance
- Ambulatory surgical center, birthing center
- Dental services related to trauma (to the teeth or mouth as a result of injury).
- Diabetic supplies and equipment,
- Durable Medical Equipment (DME): limited to prosthetic devices (with the exception of an artificial larynx), respiratory equipment and oxygen, wheelchairs, diabetic supplies and equipment, and ostomy supplies.
- Emergency room
- Eye Exam every two years
- Family planning
- Home health care includes DME that is part of your home health plan of care, (with the exception of CPAP, BiPAP, and Nebulizers).
- Hospice, if you are in the last six months of your life
- Hospital, when an overnight stay is required
- Laboratory tests and x-rays
- Maternity benefits, including certified nurse midwife
- Mental health and substance abuse
- Outpatient hospital, when an overnight stay is not required
- Personal care
- Limited Podiatry, medical services for your feet

- Pharmacy
- Primary Care Provider (PCP) services
- Specialty care with PCP referral
- Transplant related services
- Transportation to medical appointments*
- You may get these services from your MC+ Managed Care health plan or a public health agency:
  - screening, testing, and treatment for sexually transmitted diseases
  - screening and testing for HIV
  - screening, testing, and treatment for tuberculosis
  - immunizations (shots) for children
  - screening, testing, and treatment for lead poisoning

MORE BENEFITS FOR CHILDREN AND WOMEN IN A MC+ CATEGORY OF ASSISTANCE FOR PREGNANT WOMEN

A child is anyone less than twenty-one (21) years of age. For some members the age limit may be less than nineteen (19) years of age. Some services need prior approval before getting them. Call PLAN PHONE NUMBER to check. Women must be in a MC+ category of assistance for pregnant women to get these extra benefits.

- Comprehensive day rehabilitation, services to help you recover from a serious head injury
- Diabetes education and self management training
- Hearing aids and related services
- Podiatry, medical services for your feet
- Vision – Children get all their vision care from the health plan. Pregnant women get their vision care from the health plan. Pregnant women get their eye glasses in MC+ Fee-For-Service
- MC+ has a special program for children to provide medically necessary services. The program is called Early Periodic Screening, Diagnosis and Treatment (EPSDT) or Healthy Children and Youth (HCY). Your Primary Care Provider (PCP) can give your child these EPSDT/HCY services.

Some examples of EPSDT/HCY services include:

- child's medical history
- an unclothed physical exam
- blood and/or urine tests
- shots
- screening and testing lead levels in blood
- checking the growth and progress of the child
- vision, hearing, and dental screens
- dental care and braces for teeth when needed for health reasons
- private duty nurses in the home
- special therapies such as physical, occupational, and speech
- aids to help disabled children talk
- personal care to help take care of a sick or disabled child
- health care management
- psychology/counseling

An EPSDT/HCY Health Screen helps children stay healthy or find problems that may need medical treatment. Your child needs to get regular checkups. Children between 6 months and 6 years old need to get checked for lead poisoning. You may use the chart below to record when your child gets a health screen or lead poison screen.

Health Screen & Lead Poison Assessment Record		
Age	**Date of Health Screen**	**Date of Lead Poison Screen**
Newborn		
By one month		
2-3 months		
4-5 months		
6-8 months		
9-11 months		
12-14 months		Your child needs a Blood Lead Level at12 and 24 months
15-17 months		
18-23 months		
24 months		
3 years		Your child needs a Blood Lead Level each year until age 6 if in a high-risk area.
4 years		
5 years		
6-7 years		
8-9 years		
10-11 years		
12-13 years		A Blood Lead Level is recommended for women of child-bearing age.
14-15 years		
16-17 years		
18-19 years		
20 years		

Important tests your child needs are shown on the chart below: Please note these are not all the tests your child may need. Talk with your child's PCP.

Age	Test
Birth	PKU Test
1-2 Weeks	PKU and Thyroid Tests
12 months	TB Test, Blood Count, Blood Lead Level
2 years	Blood Lead Level Test
3 years	Blood Lead Level Test if in a high-risk area.
4 years	Blood Lead Level Test if in a high-risk area.
5 years	Blood Lead Level Test if in a high-risk area.
6 years	Blood Lead Level Test if in a high-risk area.

LEAD SCREENING FOR CHILDREN & PREGNANT WOMEN

Your child may be at risk for lead poisoning if:

- you live in or visit a house built before 1978.
- someone in your house works as a:
  - plumber;
  - auto mechanic;
  - printer;
  - steel worker;
  - battery manufacturer;
  - gas station attendant; or
  - other jobs that contain lead.
- There are other ways your child can be poisoned. Call PLAN PHONE NUMBER if you have questions about lead poisoning.

A lead paint chip the size of three grains of sugar can poison a small child. High levels of lead can cause brain damage or even death. Lead in children is a common health concern. Children must be tested for lead:

- Missouri state law says that children must be tested yearly if the child is between six months and six years and lives in a high-risk area;
- when the child is one year old and again at two years;
- when the child is between six months and six years and might have been exposed to lead; and
- if the child is less than six years old and has never been tested for lead.

A lead screen has two parts. First, the Primary Care Provider (PCP) will ask questions to see if your child may have been exposed to lead. Then the PCP may take some blood from your child to check for lead. This is called a blood lead level test. Children at one year old and again at two years old must have a blood lead level test. Children with high lead levels in their blood must be treated for lead poisoning.

High lead levels in a pregnant woman can harm her unborn child. If you are pregnant, talk with your PCP or obstetrician to see if you may have been exposed to lead.

IMMUNIZATION (SHOTS) SCHEDULE FOR CHILDREN

IMMUNIZATIONS (shots) help prevent serious illness. This record will help keep track when your child is immunized. If your child did not get their shots at the age shown, they still need to get that shot. Talk to your PCP about your child's immunizations (shots). Children must have their immunizations (shots) to enter school.

Immunization Record		
Age	Shot (Immunization)	Date Received
Birth	Hep B	
1 month	Hep B	
2 months	DTaP, Hib, IPV, PCV	
4 months	DTaP, Hib, IPV, PCV	
6 months	Hep B, DTaP Hib, IPV, PCV, Influenza	
12 months	Hib, PCV, MMR, Var,	
15 months	DTaP	
18 months	Good time to catch up	
2 years	Hep A Series, PPV	
4-6 years	DTaP, IPV, MMR	
11-12 years	Td	
Every Year	Influenza (after 6 months)	
Every 10 years	Td Booster (after last DTP/DTaP)	

NURSE VISITS FOR YOU AND YOUR BABY

You and your Primary Care Provider (PCP) may agree for you to go home early after having a baby. If you do, you may get two nurse visits in your home. You may get the home health nurse visits if you leave the hospital less than 48 hours after having your baby, or less than 96 hours after a C-Section. The first nurse visit will be within two days of leaving the hospital. The second nurse visit is within two weeks of leaving the hospital. You may be able to get more nurse visits if you need them.

At a home visit, the nurse will:

- check your health and your baby;
- talk to you about how things are going;
- answer your questions;
- teach you how to do things such as breast feeding; and
- do lab tests if your PCP orders them.

SPECIAL HEALTH CARE NEEDS

If you have a special health care need, call NAME OF PLAN at PLAN PHONE NUMBER. NAME OF PLAN will work with you to make sure you get the care you need. If you have a chronic illness and are seeing a specialist for your medical care, you may ask NAME OF PLAN for a specialist to be your PCP.

MENTAL HEALTH CARE

NAME OF PLAN will cover your mental health needs. A PCP referral is not needed for mental health care. You may go to any mental health provider on NAME OF PLAN's list of providers. You may get four visits in a year without our okay. Be sure to go to a mental health provider in our network. Mental health care includes care for people who abuse drugs or alcohol or need other mental health services. Call PLAN PHONE NUMBER to get mental health services.

Children who are in Alternative Care or get Adoption Subsidy get mental health care through MC+ Fee-for-Service using MC+ approved providers. These children get their physical health care from NAME OF PLAN.

FAMILY PLANNING

All MC+ Managed Care health plan members can get family planning services no matter what age. These services will be kept private. You may go to a NAME OF PLAN provider or an MC+ Fee-for-Service approved provider to get family planning services. You do not need to ask NAME OF PLAN first. NAME OF PLAN will pay for your family planning services.

CARE YOU CAN GET USING THE RED HEALTH INSURANCE CARD

You can get some health care that is not covered by NAME OF PLAN. These services are covered by MC+ Fee-for-Service using MC+ approved providers. NAME OF PLAN can help you find an MC+ approved provider for that care. Please let your Primary Care Provider (PCP) know about the care you get. This helps your PCP take care of you. This care may include the following:

- Therapy services for children in a school Individual Education Plan (IEP) or Individualized Family Service Plan (IFSP). Parents, the school, or the Department of Mental Health may start an IEP or IFSP.
- Visits by a health worker to see if lead is in your home.
- Bone marrow and organ transplants.
- SAFE/CARE exams for abused children.
- Children who are in Alternative Care or get Adoption Subsidy get mental health care through MC+ Fee-for Service using MC+ approved providers. These children get their physical health care from NAME OF PLAN.
- Community Psychiatric Rehabilitation is a special program run by the Missouri Department of Mental Health for the seriously mentally ill or seriously emotionally disturbed.
- Drug and alcohol treatment from a Comprehensive Substance Treatment and Rehabilitation (CSTAR) provider. Call NAME OF PLAN Member Services at PLAN PHONE NUMBER for a list of CSTAR providers.
- Protease Inhibitors (drugs for persons with HIV/AIDS).
- Targeted case management for mental health services.
- Abortion - (termination of a pregnancy resulting from rape, incest, or when needed to save the mother's life).
- Dental for Adults - dental services that are only related to disease or a medical condition.
- Dental for Women in a MC+ category of assistance for pregnant women - All MC+ Fee-for-Service covered dental services except for services related to trauma.
- Eyeglasses for Women in a MC+ category of assistance for pregnant women.

GETTING MEDICAL CARE

Call your Primary Care Provider (PCP) when you need health care. Your PCP's phone number is on your NAME OF PLAN card. Your PCP will help you get the care you need or refer you to a specialist.

These services do not need a PCP referral:

- Birth control or family planning - you may go to our providers or an MC+ approved provider. We will pay for this care, even if the provider is not in NAME OF PLAN.
- Mental health care - you may go to any of our mental health providers. Just call this toll free number PLAN PHONE NUMBER.
- Local public health agencies - Children may go to local public health agencies for shots. Members may go to local public health agencies for tests and treatment of sexually transmitted diseases and tuberculosis; HIV/AIDS tests; or for lead poisoning screening, testing and treatment.
- Women's health service - You may go to any of our GYN providers.
- NOTE: Plan must add any other services that do not require PCP referral: (i.e. dental, vision and others) with phone numbers.

You may have to pay for services you get if:

- you go to another health care provider without a referral from your PCP; or
- you choose to get medical services that are not covered by MC+ Managed Care.

HEALTH CARE AWAY FROM HOME

- If you need urgent health care when you are away from home, call your PCP or NAME OF PLAN at PLAN PHONE NUMBER for help.
- In an emergency, you do not need to call your PCP first. Go to the nearest emergency room or call 911.
- Call your PCP after an emergency room visit.
- Get your follow up care from your PCP.
- Routine health care services must be received from your PCP when you get back home.
- All services outside the United States and its Territories are not covered.

PHARMACY DISPENSING FEES

Pharmacy Dispensing Fees - Children under 19 do not have to pay a pharmacy dispensing fee. Members nineteen (19) and older pay a pharmacy dispensing fee for each drug they get. This fee is $0.50 up to $2.00 for each drug. The amount of this fee is based on the cost of the drug. You should never pay a fee of more than $2.00 for each drug. Remember, if you get more than one drug at the same time, you will pay these fees for each drug you get.

You will not pay a dispensing fee when the medicine is for an emergency, family planning, a foster child, EPSDT/HCY services, or a pregnancy related reason.

To ask what you have to pay call NAME OF PLAN Member Services at PLAN PHONE NUMBER.

NON EMERGENCY MEDICAL TRANSPORTATION (NEMT)

NEMT stands for Non-Emergency Medical Transportation. NEMT can be used when you do not have a way to your health care appointment without charge. We may use public transportation or bus tokens, vans, taxi, or even an ambulance, if necessary to get you to your health care appointment. NAME OF PLAN will give you a ride that meets your needs. You do not get to choose what kind of car or van or the company that will give you the ride. You may be able to get help with gas costs if you have a friend or a neighbor who can take you. This must be okayed before your appointment.

Who can get NEMT services?

- You must be in NAME OF PLAN on the day of your appointment.
- Some people do not get NEMT as part of their benefits. To check, call member services at PLAN PHONE NUMBER.
- We will only pay for one child and one parent or guardian if your child is under 21 and needs to be away from home overnight or needs someone to be with him/her. We will not pay for other children or adults.

What health care services can I get NEMT to take me to?

- The appointment is to a health care provider that is in NAME OF PLAN or takes MC+ Fee-for-Service.
- The appointment is to a service covered by NAME OF PLAN or MC+ Fee-for-Service.
- The appointment is to a health care provider near where you live. If the provider is far away, you may need to say why and get a note from your PCP. There are rules about how far you can travel to a health care appointment and get a ride.
- Some services already include NEMT. We will not give you a ride to these services. Examples are: Comprehensive Substance Treatment Abuse and Rehabilitation (CSTAR) services; hospice services; Mentally Retarded and Developmental Disability (MRDD) Waiver services; some Community Psychiatric Rehabilitation (CPR) services; adult day health care services; and services provided in your home. School districts must supply a ride to a child's Individual Education Plan (IEP) services and IEP medical related services.
- The NEMT program can take you to a durable medical equipment (DME) provider only if the DME provider cannot mail or deliver your equipment to you.
- The NEMT program will not take you to a pharmacy. Many pharmacies will mail or deliver your medicine to you.
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How do I use the NEMT program?

Call PLAN PHONE NUMBER. You must call at least INSERT NUMBER days before the day of the appointment or you may not get NEMT. You may be able to get a ride sooner if your doctor gives you an urgent care appointment. You can call this number INSERT NUMBER. If you have an emergency, dial 911, or the local emergency phone number.

EMERGENCY MEDICAL SERVICES

In an emergency, go to the nearest emergency room or call 911. When you go to the emergency room a health care provider will check to see if you need emergency care. You can call the number listed on the back of your MC+ Managed Care health plan card anytime day or night if you have questions about going to the emergency room. Call your PCP after an emergency room visit.

An emergency is when you call 911 or go to the nearest emergency room for things like:

- chest pain;
- stroke;
- difficulty breathing;
- bad burns;
- deep cuts/heavy bleeding; or
- gunshot wound.

If you aren't sure about the medical condition, get help right away or call your PCP's office for advice. Ask for a number you can call when the office is closed. You can also call NAME OF PLAN Nurse Advice Helpline at PLAN PHONE NUMBER.

It's best to call or go to your PCP's office for things that are not emergencies, like:

- earaches;
- sore throat;
- backaches;
- small cuts; or
- cold/flu.

You should call your PCP to be treated for these things. If you go to the emergency room and it is not an emergency, you may have to pay for the care you get.

Emergency medical services are those health care items and services furnished that are required to evaluate or stabilize a sudden and unforeseen situation or occurrence or a sudden onset of a medical or mental health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the failure to provide immediate medical attention could reasonably be expected by a prudent lay person, possessing average knowledge of health and medicine, to result in:

- placing the patient's physical or mental health (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
- serious impairment of bodily functions; or
- serious dysfunction of any bodily organ or part; or
- serious harm to self or others due to an alcohol or drug abuse emergency; or
- injury to self or bodily harm to others; or
- with respect to a pregnant woman who is having contractions:
  - There is inadequate time to effect a safe transfer to another hospital before delivery; or
  - Transfer may pose a threat to the health or safety of the woman or the unborn.

** Health Plans must provide locations of where to receive or obtain ER services. Therefore, the health plan should supply a list of facilities and addresses in this slot.

EMERGENCY TRANSPORTATION

Call 911 or the closest ambulance.

REGULAR HEALTH CARE APPOINTMENTS

Your PCP must see you within 30 days when you call for a regular health care appointment. Call PLAN PHONE NUMBER if you need help.

Pregnant women can see a health care provider sooner. In the first six months of pregnancy, you must be seen within seven days of asking. In the last three months of your pregnancy, you must be seen within three days of asking.
You should not have to wait longer than one hour from the time of your appointment. For example, if your appointment time is 2:00 p.m., you should be seen by 3:00 p.m. Sometimes you may have to wait longer because of an emergency. Please call NAME OF PLAN at PLAN PHONE NUMBER if you have problems or need help with an appointment. It is always important that you take your health insurance cards to your appointments.

URGENT HEALTH CARE APPOINTMENTS

Sometimes you need medical care soon, but it is not an emergency. Some examples of urgent care are:

- a fever that won't go away;
- earaches;
- a rash that won't go away;
- a pulled or strained muscle; or
- vomiting or diarrhea that doesn't stop.

For urgent health care appointments, you must be seen within the following time frames:

- for serious illnesses or injuries, appointments will be available at all times;
- for things like a high temperature and vomiting or diarrhea that won't stop, you must be seen the same day;
- for things like a rash, non-life threatening pain or fever, your provider must see you within two days.

Your PCP will treat you if he or she can. Your PCP will send you to someone else if he or she is not able to see you that soon. It is always important that you take your health insurance cards to your appointments.

MENTAL HEALTH CARE APPOINTMENTS

Appointments for mental health care are the same as for regular and urgent health care appointments.

You may see a NAME OF PLAN mental health care provider four times yearly without approval. Then after the four mental health visits, NAME OF PLAN must okay more visits. Call PLAN PHONE NUMBER. It is always important that you take your health insurance cards to your appointments.

SECOND OPINION AND THIRD OPINION

You may want an opinion from a different health care provider. In such cases, you must ask your PCP or NAME OF PLAN to get a second opinion. NAME OF PLAN will pay for it.

You may get an opinion from a third provider if your PCP and second opinion provider do not agree. NAME OF PLAN will pay for a third opinion. It is always important that you take your health insurance cards to your appointments.

CHOOSING AND CHANGING YOUR PRIMARY CARE PROVIDER (PCP)

You must choose a PCP. If you do not, we will choose one for you. Your PCP will manage your health care. The PCP knows NAME OF PLAN network and can guide you to specialists if you need one. You may ask for a specialist as your PCP if you have a chronic illness or disabling condition. We will work out a plan to make sure you get the care you need.

You have a right to change PCPs in our MC+ Managed Care health plan. (ADD EXPLANATION OF PLAN'S POLICY ON HOW FREQUENTLY CHANGES ARE ALLOWED. NOTE: Contract requires a minimum of two each year without cause.) Children in state custody may change PCP's as often as needed. To do this, call us at PLAN PHONE NUMBER. (ADD LANGUAGE ABOUT HOW LONG IT TAKES TO GET A NEW PCP).

IF YOU ARE BILLED

NAME OF PLAN will pay for all covered MC+ Managed Care services. You should not be getting a bill if the medical service you got is a covered MC+ Managed Care benefit. If you choose to pay for a service, you must agree in writing that you will be responsible for the payment before getting the service.

You will not have to pay for covered health care services even if:

- the State does not pay your MC+ Managed Care health plan.
- your MC+ Managed Care health plan does not pay your provider.
- your provider's bill is more than your MC+ Managed Care health plan will pay.
- your MC+ Managed Care health plan cannot pay its bills.

If you get a bill, do not wait! Call our Member Services office at PLAN PHONE NUMBER. NAME OF PLAN will look into this for you.

FRAUD AND ABUSE

Committing Medicaid fraud or abuse is against the law.

Fraud is a dishonest act done on purpose.

Examples of member fraud are:

- Letting someone else use your MC+ Managed Care health insurance card(s) or red health insurance card or
- Getting prescriptions with the intent of abusing or selling drugs.

An example of provider fraud is:

- Billing for services not provided.

Abuse is an act that does not follow good practices.

An example of member abuse is:

- Going to the emergency room for a condition that is not an emergency.

An example of provider abuse is:

- Prescribing a more expensive item than is necessary.

You should report instances of fraud and abuse to:

(Health Plan Name)
(Health Plan Phone Number)

or

Missouri Division of Medical Services
Recipient Services
1 (800) 392-2161

GRIEVANCES AND APPEALS

You may not always be happy with NAME OF PLAN. We want to hear from you. NAME OF PLAN has people who can help you. NAME OF PLAN **cannot take your benefits away because you make a grievance, appeal, or ask for a State Fair Hearing.**

There are two (2) ways to tell NAME OF PLAN about a problem:

GRIEVANCE or APPEAL

A Grievance is a way for you to show dissatisfaction about things like:

- The quality of care or services you received;
- The way you were treated by a provider; or
- A disagreement you may have with a MC+ Managed Care health plan policy.

An Appeal is a way for you to ask for a review when your MC+ Managed Care health plan takes action to:

- Deny or give a limited approval of a requested service;
- Deny, reduce, suspend, or end a service already approved;
- Deny payment for a service; or
- Fail to act within required time frames for getting a service.

NAME OF PLAN must give you a written Notice of Action if any of these actions happen. The Notice of Action will tell you what we did and why and give you your rights to appeal or ask for a State Fair Hearing.

YOU HAVE SOME SPECIAL RIGHTS WHEN MAKING A GRIEVANCE OR APPEAL:

1. A qualified clinical professional will look at medical grievances or appeals.
2. If you do not speak or understand English, call PLAN PHONE NUMBER to get help from someone who speaks your language.
3. You may ask anyone such as a family member, your minister, a friend, or an attorney to help you make a grievance or an appeal.
4. If your physical or mental health is in danger, a review will be done within 3 working days or sooner. This is called an expedited review. Call NAME OF PLAN and tell NAME OF PLAN if you think you need an expedited review.

5. NAME OF PLAN may take up to 14 days longer to decide if you request the change of time or if we think it is in your best interest. If NAME OF PLAN changes the time we must tell you in writing the reason for the delay.
6. If you have been getting medical care and your MC+ Managed Care health plan reduces, suspends, or ends the service, you can appeal. In order for medical care not to stop while you appeal the decision you must appeal within 10 days of receiving the written notice of action and tell us not to stop the service while you appeal. If you do not win your appeal you may have to pay for the medical care you got during this time.
7. You may request enrollment in another MC+ Managed Care health plan if the issue cannot be resolved.

HOW TO MAKE A GRIEVANCE OR APPEAL OR ASK FOR A STATE FAIR HEARING:

1. GRIEVANCE - You may file a grievance on the telephone, in person, or in writing. Call NAME OF PLAN at PLAN PHONE NUMBER to file a grievance.

    - NAME OF PLAN will write you within 10 days and let you know we got your grievance.
    - NAME OF PLAN must give written notice of a decision within 30 days.

2. APPEAL - You may file an appeal orally or in writing to NAME OF PLAN. Unless you need an expedited review, you must complete a written request even if you filed orally.

    - You must appeal within 90 days from the date of our Notice of Action.
    - For help on how to make an appeal, call NAME OF PLAN at PLAN PHONE NUMBER.
    - Send your written appeal to:PLAN ADDRESS
    - NAME OF PLAN must write you within 10 days and let you know we got your appeal.
    - NAME OF PLAN must give written notice of a decision within 45 days unless it is an expedited review.

3. STATE FAIR HEARING – You have the right to ask for a State Fair Hearing when your MC+ Managed Care health plan takes an action or when your appeal is not decided in your favor. You may ask for a State Fair Hearing orally or in writing. Unless you need an expedited review, you must complete a written request even if you asked orally.
    - You must ask for a State Fair Hearing within 90 days from the date of the MC+ Managed Care health plan's written Notice of Action or Appeal Decision Letter.
    - For help on how to ask for a State Fair Hearing, call the Division of Medical Services at 1-800-392-2161.
    - If you do not speak or understand English, call 1-800-392-2161 to get help from someone who speaks your language.
    - You can send your written request to Recipient Services Unit, Missouri Division of Medical Services, P.O. Box 6500, Jefferson City, MO 65102-6500.

- You will be sent a form to complete. Once you send the form back, a date will be set for your hearing.
- You may ask anyone such as a family member, your minister, a friend, or an attorney to help you with a State Fair Hearing.
- A decision will be made within 90 days from the date you asked for a hearing.
- If your physical or mental health is in danger, a decision will be made within 3 working days. This is called an expedited hearing. Call 1-800-392-2161 if you think you need an expedited hearing.
- If you have been getting medical care and your MC+ Managed Care health plan reduces, suspends, or ends the service, you can ask for a State Fair Hearing. In order for medical care not to stop you must ask for a State Fair Hearing within 10 days of receiving the written notice of action and tell us not to stop the service while you appeal. If you do not win, you may have to pay for the medical care you got during this time.

EASTERN MC+ Consumer Advocacy Project

(For East Use Only)

The MC+ Consumer Advocacy Project is an ombudsman service serving St. Louis City and the counties of St. Louis, Jefferson, Franklin, St. Charles, Lincoln, Warren, Washington, St. Francois, and St. Genevieve. An ombudsman is a problem solver who can advise you and help you. The MC+ Consumer Advocacy Project can help you if:

- You need help understanding your rights and benefits under MC+ Managed Care.
- You feel your rights to health care are being denied.
- You are not able to solve the problem by talking to a doctor, a nurse, or your MC+ Managed Care health plan.
- You need to talk to someone outside of your MC+ Managed Care health plan.
- You want help when filing a grievance.
- You need help when appealing a decision by your MC+ Managed Care health plan.
- You need help getting a State Fair Hearing.

For help at no cost to you, call the MC+ Consumer Advocacy Project at 314-534-1263. If calling from outside St. Louis City or county call 1-800-444-0514. You may also write to the following address:

MC+ Consumer Advocacy Project
Legal Services of Eastern Missouri
4232 Forest Park Avenue
St. Louis, MO 63108

WESTERN MC+ Advocacy Project

(For Western Use Only)

The MC+ Advocacy Project is an ombudsman service serving Clay, Platte, Jackson, Ray, Lafayette, Johnson, Cass, Henry, and St. Clair counties. An ombudsman is a problem solver who can advise you and help you. The MC+ Advocacy Project can help you if:

- You need help understanding your rights and benefits under MC+ Managed Care.
- You feel your rights to health care are being denied.
- You are not able to solve the problem by talking to a doctor, a nurse, or your MC+ Managed Care health plan.
- You need to talk to someone outside of your MC+ Managed Care health plan.
- You want help when filing a grievance.
- You need help when appealing a decision by your MC+ Managed Care health plan.
- You need help getting a State Fair Hearing.

For help at no cost to you in Clay, Platte, and Jackson counties, call 816-474-6750. If calling from Ray, Lafayette, Johnson, Cass, Henry, or St. Clair counties call 1-800-892-2943. You may also fax at 816-474-9751 or write to the following address:

MC+ Advocacy Project
1125 Grand Boulevard, Suite 1900
Kansas City, Missouri 64106

ADVANCE HEALTH CARE DIRECTIVE

You have the right to accept or refuse any medical care. A time may come when you are too sick to talk to your PCP, family, or friends. You may not be able to tell anyone what health care you want. The law allows adults to do two things when this happens:

- An advance directive allows you to leave written directions about your medical treatment decisions
- Or ask someone to decide your care for you.

If you do not have an advance health care directive, your PCP may not know what health care you want. Talk to your PCP or call NAME OF PLAN at PLAN PHONE NUMBER for information on an advance health care directive. Your PCP must keep a written and signed copy of what care you want. An advance directive becomes part of your medical record.

If there is a problem with things not being done the way they should with an advance directive, you may file a complaint with the Missouri Department of Health and Senior Services at 573-751-6400 or write them at P.O. Box 570, Jefferson City, Missouri 65102.

Advance Health Care Directives are available from the Missouri Bar:

326 Monroe
Jefferson City, MO 65101
573-635-4128

FIRST STEPS

OPTIONAL - PLAN MAY INCLUDE IN HANDBOOK OR MAKE AN INFORMATION SHEET

NAME OF PLAN can help your child get services from First Steps. First Steps is Missouri's program for infants and toddlers with special needs. First Steps helps young children with special needs and their families get services. It is for children, birth to age three, who have:

- delayed development or
- diagnosed conditions like developmental disabilities.

Children are eligible for First Steps if they have a significant delay in one or more of the following areas:

- cognition (learning);
- communication (speech or hearing);
- adaptive (self help);
- physical (walking); or
- social-emotional.

Children are referred to First Steps through:

- Physicians
- Hospitals, including prenatal and postnatal care facilities
- Parents
- Child-care programs
- Local educational agencies (including special education and Parents as Teachers)
- Public health facilities
- Other social service agencies
- Other health care providers

An assessment is done to establish eligibility and determine the needs of the child. This is:

- provided at no charge and
- arranged by the service coordinator from the SHCN or the Mental Retardation/Developmental Disabilities (MRDD) regional center.

Services are decided and listed on an Individualized Family Service Plan (IFSP) for the child. These services are provided at no cost to you, but are not a MC+ Managed Care benefit. NAME OF PLAN will refer you. First Steps and NAME OF PLAN will work together to manage your child's care.

GLOSSARY

Adoption Subsidy - subsidy services supporting a family adopting a child. Financial, medical, and support services for the child until age 18 or in some cases until age 21. These children may choose to get their health care as an MC+ Managed Care health plan member, or may choose to get health care through MC+ Fee-for-Service using MC+ approved providers.

Advance Directive - An advance directive allows you to leave written directions about your medical treatment decisions and/or ask someone to decide your care for you.

DCN - Departmental Client Number - also known as your MC+ health insurance number.

Eligibility Group - members who receive benefits based on age, family size, and income.

EPSDT - Early Periodic Screening, Diagnosis, and Treatment, also known as HCY.

HCY Program - Healthy Children and Youth, also known as EPSDT.

MC+ Approved Provider - a doctor, nurse, clinic, pharmacy, hospital, or other providers enrolled with the Division of Medical Services as an MC+ approved provider. MC+ approved providers are for care you may receive using your red health insurance card. Call 1-800-392-2161 for a list of MC+ approved providers.

MC+ Fee-for-Service - a way to get some health care services that are not covered by NAME OF PLAN. These services may be covered by MC+ Fee-for-Service. You can go to any approved provider that takes MC+ Fee-for-Service. Use only your red health insurance card. You may call 1-800-392-2191 to check on how to get these services.

MC+ Managed Care - a way to get your MC+ coverage from a MC+ Managed Care health plan in certain counties of the State. You must choose a MC+ Managed Care health plan or one will be chosen for you. You must also choose a Primary Care Provider. Use your MC+ Managed Care card and your red health insurance card to get services. While you are waiting to get in a MC+ Managed Care health plan for health care, you get services from MC+ Fee-for-Service. There are a few services that members in a MC+ Managed Care health plan will receive from MC+ Fee-for-Service. You may call 1-800-392-2161 to check on how to get services.

MC+ Managed Care Card - the card sent to you by your MC+ Managed Care health plan.

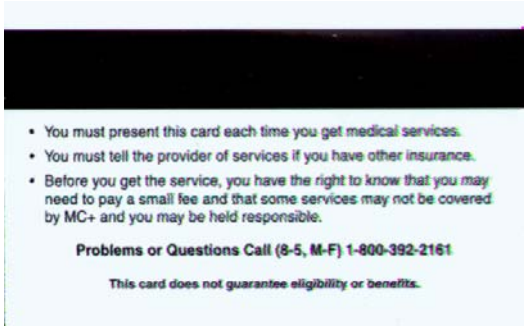
Photo of NAME OF PLAN Member I.D. Card (Front)	Photo of NAME OF PLAN Member I.D. Card (Back)

Out of Home Care/Alternative Care Services (Foster Care) - Alternative Care is the care of children living in a home other than their birth parents. The juvenile court removes the child from their home. The Children's Division then sets a plan of services.

PCP - a Primary Care Provider is a health care provider who manages a member's health care.

Prior Authorization - your MC+ Managed Care health plan's method of pre-approving certain services.

Red Health Insurance Card - the card sent to you when you are eligible for MC+.



Referrals - a process used by a PCP to let you get health care from another health care provider, usually for specialty treatment.